VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

May 18, 2010

Susan Kane, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201

Provider #: 475029

Dear Ms. Kane:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 21, 2010**. Please post this document in a prominent place in your facility.

We will follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Suzanne E. Leavitt RN, MS

Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure

PRINTED: 04/23/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475029	A. BUILDING _____ B. WING _____	C 04/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR LIVING AND REHAB	160 HOSPITAL DRIVE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was completed on 4/21/10 by the Division of Licensing and Protection.	F 000		
F 240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to care for 1 applicable resident in an environment that promotes enhancement of the resident's quality of life (Resident #1). Findings include: Per continuous observation on 4/21/10 from 11:50 AM to 1:04 PM, Resident #1, who is mostly non-verbal and is unable to initiate conversation or activity, was not provided with stimulation or interaction that would have promoted his/her quality of life. Upon arrival to the Moses/Frost dining room at 11:50 AM for the noon meal observation, Resident #1 was seated in a reclining wheelchair in front of an empty table. In the far corner of the dining room, a TV was on very quietly and Resident #1 was not engaged in watching the TV. Resident #1 remained in this same area and position without any interaction by staff or other residents, and no stimulation was provided until 12:32 PM, when the resident was brought to the shower room to	F 240	Non verbal resident with advanced chronic organic brain syndrome is engaged and stimulated in activity per care plan and daughter's specific instructions, in addition to staff care and interaction. On 4/21 resident#1 had been engaged in sensory stimulation activities as outlined in care plan. At the conclusion of the activity program all residents are taken to their dining area. Staff then begin to prepare and commence meal service at that time. Resident#1 was taken at 1150 to her dining area with other residents on her unit while staff were setting up and serving the midday meal. There is no federal standard for a required time frame to provide stimulation or social interaction with residents. At 1232 resident#1 was provided privacy for repositioning; social interaction with the resident and 2 staff members	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Susan Kane MS RN NHA Administrator 5/3/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475029	A. BUILDING ______ B. WING ______	C 04/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR LIVING AND REHAB	160 HOSPITAL DRIVE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 240	Continued From page 1 be repositioned by 2 staff. At 12:36 PM the resident was returned to the same location in the dining room with a clothing protector now in place. The noon meal was in the process of being served at this time. Resident #1 did not have any interaction with staff or other residents, nor any stimulation offered until 1:04 PM, when a staff member sat down to feed the resident his/her meal. During an interview on 4/21/10 at 2:45 PM, the Unit Manager agreed that some type of stimulation or interaction should have been provided during the time of the continuous observation.	F 240	occurred at this time. CLR has established a dining process to safely meet the neends of all residents. At 1236 the resident was returned to the dining location where the television continued to play and staff continued to follow the dining process. At 1304 staff provided Resident#1 with her mid-day meal and remained with resident for 30 minutes per resident's usual feeding routine. For Resident#1 staff will provide interaction or stimulation once during pre-meal preparation/service. A dining observation audit will be performed weekly to identify other at risk residents. Nurse managers will report weekly to DNS, who will report monthly audit results at Quality-Safety Committee meeting.	6/4/10 DNS
			CLR staff will be re-educated about social interaction/stimulation. Accepted 5-13-10 [signature]	6/4/10 DNS

CENTERS FOR LIVING AND REHABILITATION BENNINGTON, VT

QUALITY MONITORING TOOL

TOPIC: **Pre-Meal Dining Interaction Observation Audit**

UNIT:_____ **AREA:** _____

DATE: ____/____/____ **TIME:**_____

OBSERVER'S INITIALS:_____

CRITERIA	YES	NO
1. Are staff interacting or providing stimulation to residents unable to independently interact?		

If not, explain and list corrective action / coaching provided:

_____

_____

_____

_____

_____

_____

_____

05/10

SW
5/3/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475029	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 4/21/2010
NAME OF PROVIDER OR SUPPLIER: CENTERS FOR LIVING AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE: 160 HOSPITAL DRIVE BENNINGTON, VT		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain clinical records on each resident that are complete and accurately documented for 1 applicable resident (Resident #2). Findings include: Per record review and interview, the clinical record for Resident #1 failed to document an episode of combative and physically abusive behavior towards staff on 12/29/09. Per review of an internal investigation summary regarding an allegation made by Resident #2 about treatment received on 12/29/09, it stated that per staff interviews, Resident #2 was combative with care and attempting to physically assault staff on 12/29/09. Per review of the clinical record documentation for that time frame, there were no negative behaviors documented, and no documentation regarding the situation in any way. The above was confirmed with the Unit Manager during an interview on 4/21/10 at 2:45 PM. Shane 5/3/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

The above isolated deficiencies pose no actual harm to the residents